Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CLEM C MARTIN DC
207 EAST 6TH STREET
BONHAM TX 75418

Respondent Name
PROTECTIVE INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-08-4748-01

MFDR Date Received
MARCH 25, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because of the permanency of the workers injury residuals, he has been clinically at Per Need (PRN) status for majority of the nearly fourteen (14) years since his 1994 trauma. Exceptions to the PRN regimen were during the 1998, 2000 and 2006 severe flare ups that endangered his highway driving performed and caused work restriction. His PRN status and complexity of injury residuals determine [Claimant] status must be evaluated (E & M) at every presentation. This PRN regimen has been reported, billed and paid by the Carrier for the past 13 years."

Requestor's Supplemental Position Summary: "The dispute request concerned improper Current Procedural Therapy Code bundling and fee reimbursement by Carrier/Respondent…CPT Service Codes 92531 and 92532-Bundling dispute withdrawal. Requestor withdraws request for Medical Review Division (MDR) adjudication of CPT service codes 92531 and 92532 – Nystagmic testing. (CMS (Medicare) Fee Guidelines designate these CPT Codes a Relative Value Unite (RVU) score of '0' with 'status Code B' indicating these services are bundled into other services."

Amount in Dispute: $132.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "this Requestor has billed for several services each day that have been unbundled from other services in order to obtain additional reimbursement to which they are not entitled pursuant to the fee guidelines. Therefore, no monies are owed."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2007	Office Visit - CPT Code 99214-25	$71.00	$71.00
October 24, 2007	Office Visit - CPT Code 99213-25	$61.63	$61.63
TOTAL		$132.63	$132.63

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 25-Separate E&M Service, Same Physician
   - B15-Procedure/Service is not paid separately.

Issues

1. Are the evaluations and management (E&M) services unbundled from the chiropractic manipulation?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(a)(3) "Notwithstanding Centers for Medicare and Medicaid Services (CMS) payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act."

   28 Texas Administrative Code §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   On the disputed dates of service, the requestor billed for an E&M code and a chiropractic manipulation code 98940. The respondent denied reimbursement for the E&M codes based upon reason code "B15."

   According to CCI edits, the E&M codes 99214 and 99213 are bundled into 98940; however, a modifier is allowed to differentiate the service. The requestor appended modifier "25-Significant, Separately Identifiable E&M service" to codes 99214 and 99213.

   A review of the submitted documentation finds that the requestor supported billed services; therefore, the respondent's denial based upon "B15" is not supported.

2. 28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 99214 in Bonham, Texas, Medicare Locality Rest of Texas, is $85.09. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $106.36. The requestor is seeking reimbursement of $71.00. The respondent paid $0.00. As a result, reimbursement of $71.00 is recommended.

   The Medicare allowable for CPT code 99213 in Bonham, Texas, Medicare Locality Rest of Texas, is $56.03.

Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $70.03. The requestor is seeking reimbursement of $61.63. The respondent paid $0.00. As a result, reimbursement of $61.63 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $132.63.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $132.63 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/17/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.